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ABSTRACT

This paper discusses ethical considerations involved in breach of confidentiality in counseling dangerous clients, i.e., those who have the potential to inflict bodily harm on others. The ethical basis for confidentiality is presented in a model for decision making in ethical dilemmas which encompasses three evaluative levels or tiers: ethical rules, ethical principles, and ethical theories. Each of these levels, from the most concrete (rules) to the most abstract (theories), is discussed as it supports confidentiality. Limits on confidentiality, the effects of breaching confidentiality, and the difficulty in predicting dangerousness are discussed. Options for dealing with dangerous clients, exclusive of the duty to warn others of the client's dangerousness are proposed, presented in order of degree of severity of violations of the client's autonomy and confidentiality: (1) releasing the client on his/her own recognizance with counselor support; (2) releasing the client to parents/spouse/friends with counselor support; (3) holding and treating, by moving the client, using force if necessary, to a locked treatment facility for extended evaluation. (MCF)

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ETHICAL CONSIDERATIONS IN MAINTAINING CONFIDENTIALITY WITH DANGEROUS CLIENTS

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From time to time a counselor may be required to assess dangerousness in a client, either formally or informally. Clearly dangerousness includes both auto-lethality and danger to others. In this paper, we will be concerned with the dangerousness toward others. In any such case where a client presents a potential threat to specified members of the community, or the community as a whole, the counselor is faced with an ethical dilemma which involves client-counselor confidentiality.

Thus, the purpose of this paper is to discuss confidentiality, what it is, where it comes from and why it is important. Legal and ethical constraints will be discussed, specifically in regard to dangerous clients. Some guidelines for action with dangerous clients will be given along with ethical considerations of these guidelines.

Confidentiality is the nonrevelation of information considered to be private. It is not the same as privacy, but the two are related. Privacy has to do with a state of secrecy, here the secret communications between client and therapist. Confidentiality has to do with the invasion or protection from invasion, of that privacy (Everstone, Everstone, Heymann, True, Frey, Johnson and Seiden, 1980).

There are many potential breaches of confidentiality such as information on insurance forms, availability of records, even office gossip. This paper will deal strictly with ethical considerations involved in breach of confidentiality with

clients who are potentially criminally dangerous to the community. Dangerous here is defined as potentially inflicting bodily injury on another.

Confidentiality between client and therapist seems to be so universally supported that further elaboration is not necessary. But what is the ethical basis for confidentiality? Kitchener (1982) has proposed a model for organizing action in ethical dilemmas. The model encompasses an intuitive level for immediate judgements and a critical, evaluative level for building an ethical basis from which to make future ethical judgements. Within this critical evaluative level are three tiers. These tiers, listed moving from the concrete to the abstract, are ethical rules, ethical principles and ethical theories. Confidentiality is justified at all three of these tiers.

Ethical Rules

Ethical rules encompass such documents as professional codes and laws. They are an attempt to codify ethical principles and provide a course of action. Kitchener (1982) states that ethical rules "are the first line of ethical justification to which we may appeal to evaluate our moral intuitions."

The APGA Ethical Standards (Callis, Pope & DePauw, 1982) are such a set of rules. Much of section B, entitled Counseling Relationship, is devoted to confidentiality. Subsection B.2 notes the importance of confidentiality to the counseling relationship, while subsection B.4 places limits

on it. Specifically, subsection B.4 states that if "there is a clear and imminent danger to the client or others, the member must take reasonable personal action or inform responsible authorities" (Callis, et al, 1982). "Others" here is not specifically defined but, as will be seen later, has been somewhat delimited by court decisions.

Similarly, the APA Ethical Principles of Psychologists (EPP), which are in fact rules rather than principles, support limited confidentiality. Principle 5 of the EPP is entitled Confidentiality, and is entirely devoted to that topic. Like the Ethical Standards, the EPP also mentions the undefined, but later delimited, "others" (APA, 1981).

Additionally, many states have some form of limited privileged communication law for psychologists. In some states, counselors working under the supervision of a psychologist are also protected. Some states have limited protection for those working in a setting, such as a mental health center, who regularly perform psychological services. In others, the law is not explicit and will remain so if and until such a case is brought to court. Thus, those laws serve as a guide to the limits of confidentiality and are not absolute.

Ethical Principles

Beauchamp and Childress (1979) list four ethical principles: autonomy, beneficence, nonmaleficence and justice. Kitchener (1982) adds a fifth, fidelity. These principles are the root from which ethical rules are derived. They are more general and are the next ethical level to turn to when

ethical rules are not explicit, are inadequate or are in conflict. Ethical principles are considered prima facie binding on the counselor unless two or more conflict. In such a case, the ethical principles must be ordered in accordance with the situation.

Confidentiality by itself is not an ethical principle, rather, it is considered to be a rule (Beauchamp and Childress, 1979). Confidentiality is derived from two ethical principles, autonomy and beneficence. How each principle relates to confidentiality will be discussed next.

Autonomy can be defined as the right of a competent person to freedom of action, that is, to do what one wants so long as it does not infringe on another's rights, and freedom of choice, where one can make one's own judgements (Kitchener, 1982; Beauchamp and Childress, 1979). Additionally, autonomy has two aspects. The first is the right to act and think autonomously. The second aspect is, given that one demands autonomy for oneself, to respect this same right in others (Kitchener, 1982).

The principle of autonomy presupposes that the individual is competent. While competence has many components, it generally can be taken to mean that the individual has the ability to think and act rationally. Associated with the concept of competence are those of limited competence and intermittent competence. Limited competence means that the individual is competent only in certain situations or environs. A client living in a group home may be competent within this

structure, but not competent to live entirely on his own. Intermittent competence is more time related, that is, an individual may be competent at one moment and incompetent at another such as the earlier stages of Altzheimer's disease.

Confidentiality's basis in autonomy is primarily from the second aspect described above. A competent person who exercises a "deviant" belief or behavior has the right to that belief or behavior and, at some level, the right to be respected in spite of it. (This of course is limited to instances where a third person's rights are not infringed upon. Such an infringement clearly violates that third person's autonomy. This, therefore, is a violation by the second person of the principle of autonomy. Specifically, it is a violation of the second aspect which calls for respect for another's autonomy.) Respect for a person's autonomy encompasses his right to privacy. Violating confidentiality is a violation of both privacy and respect for the right to hold a belief system. Thus it is a violation of a person's autonomy.

Beneficence is generally defined as the promotion of good. However, it also refers to the prevention of harm and removal of harmful conditions (Beauchamp and Childress, 1979). There are two aspects to beneficence. One needs to differentiate between beneficence to the client and beneficence to the community. While the Ethical Standards and the EPP imply that a counselor owes a primary duty to the client, there are limitations on this duty. Sometimes beneficence to the client

and beneficence to the community conflict and an ethical dilemma results. While there are a number of therapeutic aspects to beneficence, with dangerous clients the relation of beneficence to autonomy is quite salient. Therapeutically, a client is generally best served by granting him or her the right to autonomous choices. That is, to remove the autonomy of a competent person may be seen as harming that person. Thus, other therapeutic aspects aside, the principle of beneficence is best served by allowing autonomy.

The concept of paternalism is associated with both autonomy and beneficence. In general, the principle of autonomy prevails over that of beneficence for the competent client. Paternalism is a case where the opposite is true, beneficence prevails over autonomy. In such a case, a counselor, or a person in a position of power can decide what is "best" for another person rather than allowing that person the decision. The "best" thing to do is then imposed upon that person.

Beauchamp and Childress (1979) further delineate between strong and weak paternalism. Weak paternalism occurs when autonomy, the right to decide, is removed from an individual whose conduct is considered to be substantially nonvoluntary. Strong paternalism occurs when this individual's behavior is considered to be informed and voluntary. Note that the individual's behavior, not his thinking, is the measure. Weak paternalism is considered to be acceptable, strong paternalism is generally considered to be inappropriate because of the

high value placed on the autonomy of a competent person in Western society.

Ethical Theories

Finally among the three tiers are ethical theories. It is from ethical theory that ethical principles, and thereby ethical rules are derived. Two prominent theories which have enjoyed longstanding popularity are deontology and utilitarianism. While these theories can be further subdivided, a general definition of each will suffice.

Utilitarianism holds that "we ought in all circumstances to produce the greatest possible balance of value over disvalue for all persons affected" (Beauchamp and Childress, 1979, p. 21). This means that the benefits should be maximized and risks minimized for all concerned. These benefits are seen as consequences of the actions.

Utilitarianism justifies confidentiality in therapy by assuming that it is necessary for any real work to be done. Since confidentiality exists, the client is freer to speak, knowing that his or her "bad" side will remain a personal matter. The client will not suffer the embarrassment, at least, of having personal information disclosed. The client thus has a better chance of improving. In turn, the community benefits from having a "healthier" member.

Confidentiality is also supported by deontology. Deontology holds "that features of some acts other than their consequences make them right or wrong" (Beauchamp and Childress, 1979). In other words, some acts are inherently

right or wrong.

Confidentiality is supported by deontological theory through the principle of autonomy. Autonomy states that an individual has the right to privacy and the right to control over such privacy. This control over privacy is confidentiality. For a deontologist, it is not necessarily the consequences of a specific action which serve as an ethical guide, but the "rightness" of each action.

Limits of Confidentiality

The rule of confidentiality enjoys great support from ethical rules, ethical principles and ethical theories. Like the ethical principles that support it, confidentiality should be considered as prima facie binding within certain limits. Some of these limits are practical such as insurance forms and office access to files. For example, how much can a counselor promise that what happens in a therapy session is confidential? If third party billing is involved, the third party may require diagnosis, prognosis and even a case review by their own staff. In an office, many people have practical access to files including secretaries, filing clerks, etc. If such potential violations of confidentiality are discussed, the violations may be ethically satisfied by the use of informed consent with the client.

Other potential breaches of confidentiality are more difficult from an ethical standpoint. Specifically, certain conflicts exist when the counselor encounters a potentially dangerous client. Some of these conflicts have been brought

to court and rules developed to guide future actions.

For counselors, perhaps the most prominent case is the Tarasoff decision (Beauchamp and Childress, 1979). Briefly, a psychologist at the University of California student health center had knowledge of a threat by a client, Prosenjit Podder, to kill Tatiana Tarasoff. The psychologist broke confidentiality and had Podder detained by the University police. In the custody of the police, Podder appeared lucid and promised to leave Tarasoff alone. Upon her return from vacation however, Podder killed her. Tarasoff's parents brought suit because the psychologist did not warn them or their daughter. The court found for the plaintiffs.

It should be noted that the psychologist was actually adhering to the then current Ethical Standards of Psychologists. The current EPP has been changed since this court decision (APA, 1981). Thus, the current ethical rule and law states that a psychologist possessing knowledge of a clear and present danger to a third party is at duty to warn the third party. The APGA Ethical Standards reflect this also (Callis, et al, 1982).

Gehring (1982) cited cases in which the courts have further defined the duty to warn. Psychologists, for the time being at least, have no legal duty to warn or break confidentiality unless the victim or group of victims is readily foreseeable. A non-licensed counselor's legal position may vary from state to state. However, there are ethical responsibilities which may be different than the legal ones.

Consider a client who appears to have the potential to be dangerous, but to no specific person or group of persons. Legally, there is no duty to warn. But, certainly the counselor wishes to prevent harm to the community if that is possible. At the same time, the counselor wishes to act in the most ethical manner possible with both the community and the client. This can often pose an ethical dilemma.

Lane and Spruill (1980) concluded it is difficult to predict dangerousness, particularly with clients who have no history of dangerous behavior. Kozol, Boucher and Garofalo (1972) noted that many people are detained due to the actions of a few. The tendency is apparently to over-predict dangerousness when doubt occurs. It is easy to see how this overprediction comes about.

When dealing with the doubt inherent in an ethical dilemma, potential ill effects of the various decisions are compared. One aspect of these ill effects is their reversibility. Death or serious injury to an innocent person is irreversible. Contrast these effects with reducing one person's freedom. There is some chance of danger to physical health in being incarcerated. More likely is some mental trauma which may or may not be reversible. For the most part however, the effects of incarceration are likely to be considered short-term and reversible and thus less serious. Clearly one would opt for the less serious effect. Of course the flaw in this argument is that the above may hold true if an assault occurs. As previously stated, there is a tendency

toward overprediction.

What are some of the long-term effects to psychotherapy if counselors continue to err on the side of safety? Potentially, confidence in the counselor's willingness to maintain confidentiality will diminish. This confidence is necessary to continue therapeutic work. In support of this, it should be noted that after he was even temporarily detained, Podder in the Tarasoff case did not return to therapy. In his minority decision in the Tarasoff case, Justice Clark advanced exactly this position and wrote that "without substantial assurance of confidentiality, those requiring treatment will be deterred from seeking assistance." (quoted in Beauchamp and Childress, 1979, p. 248) In the long run Justice Clark saw an increase in danger to the community as a result of breaking confidentiality.

On the other hand there are real and practical effects to counselors if underprediction of violence occurs. If the community perceives that counselors are not interested in their safety, it might react by enacting laws which require even more disclosure on the part of the counselor.

Ethical Actions

Some options for dealing with dangerous clients exclusive of a duty to warn will now be presented. The appropriateness of each option must be measured according to the perceived dangerousness of the client. Prediction of dangerousness is a treatment issue. While this paper is concerned with ethical rather than treatment issues, it is impossible to meaningfully

discuss ethical issues in a vacuum. Thus while the options to be presented will be considered from an ethical standpoint, some guidelines for appropriateness will be presented. The guidelines should not be considered exhaustive.

All of the options involve a breach of confidentiality, and they will be ordered in increasingly severe violation of the client's autonomy. In terms of treatment, they will be ordered on the amount of self control exhibited by the client, from high to low. It should also be noted that neither the treatment nor the ethical issues can be viewed as discreet steps, but instead should be viewed on a continuum. The purpose of these guidelines is to balance to the highest degree possible the legitimate ethical rights of both the client and individuals in the community.

Client's own recognizance with counselor support

In this instance the client is released with no support system directly involved other than the counselor. (Hopefully the client does have a support system of family and/or friends. However at this point they are not actively involved in the therapeutic picture.) The counselor and/or a backup such as another counselor or crisis center should be available twenty-four hours per day. A contract can be established with the client to call should the need arise.

The client's autonomy is violated only slightly because he or she does not have to call. At the same time, support is available and in some cases may be a deterrant in and of itself. There is some limited breach of confidentiality, and

thereby autonomy, due to the involvement of a back-up. Such a situation should be agreed to in advance with the client through informed consent.

Beneficence to the client may be aided by the likelihood of continued treatment. But since the client is out free with only voluntary controls to aid him, some risks to the community still exist. Thus there is a possible violation of ~~non-maleficence~~ beneficence to the community.

Because of the voluntary controls inherent in this first option, it should be considered only for clients who exhibit strong self-control and no previous history of dangerous behavior. Concern for the dangerousness of the situation and willingness to cooperate through use of a contact should also be exhibited.

Release to parents/spouse/friends with counselor support

Obviously this may not be a viable option. The counselor must be careful that these "supports" are not collaborating in the dangerous behavior. Even if they are not collaborators, these people may be unable to control this client or even be willing to take on that responsibility. Such a situation places these people into a social control position, one they are not likely to be accustomed to. These people can help nonetheless by being in more direct contact with the client than could an individual counselor. Thus they could exert more control to keep the client away from the dangerous behavior, and help ensure that the client continues treatment.

On the other hand, the client might object strenuously to involving significant others. For some, the potential embarassment and anger over being controlled might make this a less than viable option.

Ethically, autonomy is minimally violated because some of the client's free choice has been curtailed. It is a more severe violation of the confidentiality aspect of autonomy in that significant others are brought into what otherwise might be a private matter. For the counselor, it requires somewhat of a more paternalistic stance. Beneficence is again upheld because treatment can continue. To the extent that these sound supports actually do aid in controlling the client's behavior, ~~nonmaleficence~~ beneficence to the community is also upheld.

This second option might be considered for those who have a short history of less severely dangerous behavior and may demonstrate a "fear" of acting out again but not an express desire. They should also show enough impulse control that such support would actually be useful. Concern and cooperation are also critical. Obviously, the client who refuses this support, who refuses to continue treatment demonstrates that he does not have the impulse control or cooperative ability to function at this level or at the first level. Such a client should be considered for a hold and treat.

Hold and treat

A hold and treat consists of moving the client, by force if necessary, to a locked treatment facility for a more

extended evaluation. This is an entirely paternalistic position that breaks confidentiality and removes all autonomy from the client. Ethically, the burden of proof for such a commitment is on the counselor, although legally in most states, it falls upon the psychologist or psychiatrist with the power to commit. Such a drastic reduction in a person's autonomy requires substantial evidence to support dangerousness.

The chief purpose of a hold and treat is to protect the community from the dangerous client, or the client from herself, as the case may be. Thus, ~~nonmaleficence~~ beneficence to the community is upheld as the dangerous client is entirely supervised for the length of time of the commitment. In confinement, the client would likely undergo treatment and be prevented from getting herself into further legal difficulties. Thus beneficence to the client would be served, but, as the definition of paternalism states, at the expense of autonomy.

As previously stated, strong evidence must exist as to the client's dangerousness to the community before such a step is taken. A client with a significant history of dangerousness, poor impulse control and/or who makes threats to specific persons or groups of persons should be considered. Clients exhibiting no genuine remorse or willingness to accept voluntary curbs on their behavior are also candidates. At this level of behavior, the counselor should be on guard for the client who recently committed a crime and is anticipating arrest. "Voluntarily" appearing for counseling may simply be

an attempt to appear contrite before a judge.

A disclaimer is in order. There are those who would argue (correctly) that assurances of self-control, support and remorse could easily be faked and the previous guidelines useless. But in the absence of other information, what other choices are available? The counselor is simply making an educated guess. Additionally, if the client admits to an unreported crime, the counselor should try to persuade the client to report himself. This is true because the counselor has an obvious ethical duty to the community, but also from a therapeutic standpoint. A goal of therapy in such a case would undoubtedly be taking responsibility for one's own actions. Effective therapy is not likely to start until such a condition exists.

Summary

Confidentiality is an important and accepted aspect of the counseling relationship. It is supported by ethical rules, principles and theories. At the same time there are limits on confidentiality. While there are legal and ethical duties to break confidentiality in certain instances with dangerous clients, situations where there is no known victim present only ethical duties. These duties require a balancing of client versus community rights.

When encountering such a client, the rights of the client must be weighed against the rights of the community. Since the client's rights tend to be violated more frequently than the

community's rights, counselors must become more sensitive to potential alternatives, their ethical bases and potential effects.

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